Senate

General Assembly

File No. 34

February Session, 2006

Substitute Senate Bill No. 409

Senate, March 20, 2006

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT ESTABLISHING THE NUTMEG HEALTH PARTNERSHIP INSURANCE PLAN.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2006*) There is established a Nutmeg Health Partnership Insurance Plan. The plan shall consist of the measures set forth in sections 2 and 3 of this act and sections 38a-497 and 38a-554 of the general statutes, as amended by this act, for the purpose of making health insurance accessible and affordable for residents of this state.

Sec. 2. (NEW) (*Effective October 1, 2006*) (a) Notwithstanding the provisions of chapter 700c of the general statutes, the Insurance Commissioner may approve any individual health insurance policy or certificate which contains the minimum coverages or benefits set forth in section 38a-503c and subsection (c) of section 38a-504 of the general statutes in addition to those required under subsection (c) of section 38a-505 of the general statutes.

(b) Notwithstanding the provisions of chapter 700c of the general statutes, the Insurance Commissioner may approve any individual health insurance policy or certificate which (1) contains the following minimum coverages or benefits set forth in chapter 700c of the general statutes: Subdivision (2) of subsection (b) of section 38a-476, sections 38a-476b, 38a-483c, 38a-489, 38a-496, 38a-498a, 38a-502, 38a-503b and 38a-503c and subsection (c) of section 38a-504 of the general statutes, in addition to those required under subsection (c) of section 38a-505 of the general statutes, and (2) offers the following minimum coverages or benefits set forth in chapter 700c of the general statutes as options: Sections 38a-488a, 38a-490 to 38a-490c, inclusive, 38a-491a, 38a-492 to 38a-493, inclusive, 38a-498, 38a-503, 38a-503d, 38a-503e, subsections (a) and (b) of section 38a-504, 38a-504a to 38a-504g, inclusive, and sections 38a-507 to 38a-509, inclusive, of the general statutes, provided the insurer, at the time of initial issuance and upon renewal, shall offer the options specified in subdivision (2) of this subsection and receive the acceptance or declination of the insured, in writing, which offer shall include a description of the coverages or benefits and the cost associated with each such coverage or benefit.

Sec. 3. (NEW) (*Effective July 1, 2006*) (a) As used in this section:

(1) "Commissioner" means the Insurance Commissioner; and

(2) "Ineligible population" means (A) part-time employees, seasonal employees and independent contractors who are not eligible to participate in a group health insurance policy offered by an employer or in any other group health insurance policy, as determined by the commissioner, and (B) retired employees under the age of sixty-five who are not eligible to participate in a group health insurance policy offered by a former employer or in any other group health insurance policy, as determined by the commissioner.

(b) Notwithstanding the provisions of chapter 700c of the general statutes, the Insurance Commissioner may approve any group health insurance policy or certificate which does not contain all the minimum coverages or benefits set forth in chapter 700c of the general statutes,

provided such policy or certificate is approved only for issue to the ineligible population in this state.

Sec. 4. Section 38a-497 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

[Every**]** Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, amended or renewed in this state on or after October 1, **[**1982**]** 2006, shall provide that coverage of a child shall terminate no earlier than the policy anniversary date on or after whichever of the following occurs first, the date on which the child marries, ceases to be a dependent of the policyholder **[**,**]** or attains the age of **[**nineteen if the child is not a full-time student at an accredited institution, or attains the age of twenty-three if the child is a full-time student at an accredited institution**]** twenty-six.

Sec. 5. Section 38a-554 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2006*):

A group comprehensive health care plan shall contain the minimum standard benefits prescribed in section 38a-553, as amended, and shall also conform in substance to the requirements of this section.

(a) The plan shall be one under which the individuals eligible to be covered include: (1) Each eligible employee; (2) the spouse of each eligible employee, who shall be considered a dependent for the purposes of this section; and (3) dependent unmarried children **[**,**]** who are under the age of **[**nineteen or are full-time students under the age of twenty-three at an accredited institution of higher learning**]** twenty-six.

(b) The plan shall provide the option to continue coverage under each of the following circumstances until the individual is eligible for other group insurance, except as provided in subdivisions (3) and (4) of this subsection: (1) Notwithstanding any provision of this section,

upon layoff, reduction of hours, leave of absence, or termination of employment, other than as a result of death of the employee or as a result of such employee's "gross misconduct" as that term is used in 29 USC 1163(2), continuation of coverage for such employee and such employee's covered dependents for the periods set forth for such event under federal extension requirements established by the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended from time to time, (COBRA), except that if such reduction of hours, leave of absence or termination of employment results from an employee's eligibility to receive Social Security income, continuation of coverage for such employee and such employee's covered dependents until midnight of the day preceding such person's eligibility for benefits under Title XVIII of the Social Security Act; (2) upon the death of the employee, continuation of coverage for the covered dependents of such employee for the periods set forth for such event under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended from time to time, (COBRA); (3) regardless of the employee's or dependent's eligibility for other group insurance, during an employee's absence due to illness or injury, continuation of coverage for such employee and such employee's covered dependents during continuance of such illness or injury or for up to twelve months from the beginning of such absence; (4) regardless of an individual's eligibility for other group insurance, upon termination of the group plan, coverage for covered individuals who were totally disabled on the date of termination shall be continued without premium payment during the continuance of such disability for a period of twelve calendar months following the calendar month in which the plan was terminated, provided claim is submitted for coverage within one year of the termination of the plan; (5) the coverage of any covered individual shall terminate: (A) As to a child, the plan shall provide the option for said child to continue coverage for the longer of the following periods: (i) At the end of the month following the month in which the child marries, ceases to be dependent on the employee or attains the age of **[**nineteen**]** twenty-six, whichever occurs first. **[**,

except that if the child is a full-time student at an accredited institution, the coverage may be continued while the child remains unmarried and a full-time student, but not beyond the month following the month in which the child attains the age of twenty-three.**]** If on the date specified for termination of coverage on a dependent child, the child is unmarried and incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the employee for support and maintenance, the coverage on such child shall continue while the plan remains in force and the child remains in such condition, provided proof of such handicap is received by the carrier within thirty-one days of the date on which the child's coverage would have terminated in the absence of such incapacity. The carrier may require subsequent proof of the child's continued incapacity and dependency but not more often than once a year thereafter, or (ii) for the periods set forth for such child under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended from time to time, (COBRA); (B) as to the employee's spouse, at the end of the month following the month in which a divorce, court-ordered annulment or legal separation is obtained, whichever is earlier, except that the plan shall provide the option for said spouse to continue coverage for the periods set forth for such events under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended from time to time, (COBRA); and (C) as to the employee or dependent who is sixty-five years of age or older, as of midnight of the day preceding such person's eligibility for benefits under Title XVIII of the federal Social Security Act; (6) as to any other event listed as a "qualifying event" in 29 USC 1163, as amended from time to time, continuation of coverage for such periods set forth for such event in 29 USC 1162, as amended from time to time, provided such plan may require the individual whose coverage is to be continued to pay up to the percentage of the applicable premium as specified for such event in 29 USC 1162, as amended from time to time. Any continuation of coverage required by this section except subdivision (4) or (6) of this

subsection may be subject to the requirement, on the part of the individual whose coverage is to be continued, that such individual contribute that portion of the premium the individual would have been required to contribute had the employee remained an active covered employee, except that the individual may be required to pay up to one hundred two per cent of the entire premium at the group rate if coverage is continued in accordance with subdivision (1), (2) or (5) of this subsection. The employer shall not be legally obligated by sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, as amended, to pay such premium if not paid timely by the employee.

(c) The commissioner shall adopt regulations, in accordance with chapter 54, concerning coordination of benefits between the plan and other health insurance plans.

(d) The plan shall make available to Connecticut residents, in addition to any other conversion privilege available, a conversion privilege under which coverage shall be available immediately upon termination of coverage under the group plan. The terms and benefits offered under the conversion benefits shall be at least equal to the terms and benefits of an individual comprehensive health care plan.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2006*	New section
Sec. 2	*October 1, 2006*	New section
Sec. 3	*July 1, 2006*	New section
Sec. 4	*October 1, 2006*	38a-497
Sec. 5	*October 1, 2006*	38a-554

INS *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 07 $	FY 08 $
State Comptroller - Fringe Benefits	Various - Cost	None	Indeterminate
Insurance Dept.	IF - None	None	None

Note: IF=Insurance Fund

Municipal Impact:

Municipalities	Effect	FY 07 $	FY 08 $
Various Municipalities	Cost	Potential Indeterminate	Potential Indeterminate

Explanation

The bill by requiring insurance policies that cover dependent children to provide coverage until the age of 26 will result in increased health service costs to the state as an employer, beginning in FY 08. Under the bill, certain employees will maintain the more costly family coverage for longer than currently permitted. Data related to coverage of adult children to age 26 is not readily available, so an exact cost estimate cannot be determined at this time.

The bill's impact on municipal health insurance costs will vary based on existing municipal coverage. To the extent that the dependent coverage required under the bill is not currently provided under a municipality's employee health insurance policy, there would be increased costs to provide it that cannot be determined.

The bill could affect the workload of the Department of Insurance but is not anticipated to result in the need for additional resources.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis
sSB 409

AN ACT ESTABLISHING THE NUTMEG HEALTH PARTNERSHIP INSURANCE PLAN.

SUMMARY:

This bill establishes the Nutmeg Health Partnership Insurance Plan through which the insurance commissioner can approve health insurance policies or certificates that do not contain all the benefits currently mandated for (1) independent contractors and employees not eligible for an employer's group health insurance policy and (2) individuals. (There are two versions of individual plans that she may approve.) It also requires insurance policies that cover dependent children to provide coverage until the child turns age 26, instead of age 19 or, if a full-time student, age 23.

EFFECTIVE DATE: July 1, 2006, except for the individual policy and dependent age provisions, which are effective October 1, 2006.

GROUP HEALTH INSURANCE

Ineligible Population

The bill permits the insurance commissioner to approve group health insurance policies and certificates for Connecticut's ineligible population that do not comply with state benefit mandates. "Ineligible population" means (1) part-time and seasonal employees and independent contractors who are not eligible for an employer-sponsored or other group health insurance policy and (2) retired employees age 64 or younger who are not eligible for a former employer's or other group health insurance policy.

INDIVIDUAL HEALTH INSURANCE

Individual Policy with Minimum Coverage

The bill permits the insurance commissioner to approve individual health insurance policies and certificates that do not comply with the current mandated benefits but that, instead, cover (1) breast reconstruction after a mastectomy, (2) coverage for a minimum length of hospital stay for mother and newborn after delivery, and (3) minimum benefits she determines in regulations for hospital, medical-surgical, major medical, disability income, accident only, and specified accident coverage. (Breast reconstruction and maternity hospital stay benefits are based on federal law requirements.)

Individual Policy with Minimum Coverage and Optional Benefits

The bill permits the commissioner to approve individual health insurance policies and certificates that (1) cover minimum benefits she determines in regulation for hospital, medical-surgical, major medical, disability income, accident only, and specified accident coverage; (2) include some current state mandates; and (3) offer other benefits currently mandated as optional benefits. The insurer must, when first issuing a policy and at each renewal, (1) offer the optional benefits, (2) describe each benefit and its associated cost for the insured, and (3) obtain the insured's acceptance or refusal of each benefit in writing.

The mandated provisions that have to be included in a reduced mandate policy are:

1. preexisting benefit exclusion limitation of no more than 12 months,

2. no limit on access to the most effective psychotropic drugs under mental health benefits,

3. coverage for experimental treatments that have completed a Phase III FDA clinical trial,

4. coverage for a handicapped dependent child following the normal coverage termination date for children,

5. coverage for occupational therapy if physical therapy is

covered,

6. no preauthorization requirement for 9-1-1 calls,

7. coverage for services provided by the Veteran's Home and Hospital,

8. direct access to an obstetrician-gynecologist,

9. breast reconstruction after a mastectomy, and

10. coverage for a minimum length of hospital stay for mother and newborn after delivery.

The covered benefits that are currently mandatory but, under the bill, must instead be offered as optional are:

1. mental health benefits subject to the same terms as physical health conditions ("parity");

2. newborns from birth and adopted children from legal placement;

3. early childhood intervention services ("birth-to-three");

4. hearing aids for children under age 13;

5. craniofacial disorder treatment for children under age 18;

6. anesthesia and related hospital services for dental services;

7. emergency medical care for the accidental ingestion or consumption of controlled drugs;

8. hypodermic needles and syringes prescribed for administering medication;

9. off-label cancer drugs (a drug recognized for treating a specific type of cancer but prescribed for another);

10. modified food products for the treatment of inherited metabolic

diseases and cystic fibrosis, including specialized formula for children up to age 8;

11. diabetic testing, self-management training, equipment, drugs, and supplies;

12. prescription drugs removed from a drug formulary list if the patient was using it for chronic disease treatment;

13. prostate cancer screening for men who have symptoms or family history or are over age 50;

14. Lyme disease treatment;

15. pain treatment ordered by a pain management specialist;

16. ostomy-related appliances and supplies (if the policy covers ostomy surgery);

17. colorectal cancer screening;

18. home health care;

19. medically necessary ambulance service;

20. mammograms;

21. minimum length of hospital stay following a mastectomy;

22. contraceptives (if the policy covers prescription drugs);

23. chiropractic services;

24. treatment for leukemia and tumors, including outpatient chemotherapy, reconstructive surgery, and non-dental prosthesis;

25. wigs for chemotherapy patients;

26. cancer clinical trials;

27. breast cancer screening by ultrasound; and

28. infertility testing and treatment.

DEPENDENT AGE

The bill requires insurance policies that cover dependent unmarried children to cover a child until he turns age 26. Current law requires the coverage until he turns age 19, or, if he is a full-time student at an accredited institution, age 23. The dependent age provision applies to:

1. individual health insurance policies that cover basic hospital expenses, basic medical-surgical expenses, major medical expenses, accidents only, limited benefits, and hospital or medical services, including those provided by HMOs, and

2. group comprehensive health care plans, including coverage continued after an employee's layoff, reduction of hours, leave of absence, or termination.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 13 Nay 2 (03/09/2006)